

State of Connecticut
Department of Consumer Protection
Commission of Pharmacy
165 Capitol Avenue, Room 147
Hartford, CT 06106 - Telephone: 860-713-6070



Pharmacy Intern Preceptor's Statement

Part I: To be completed by the Pharmacy Intern

I hereby certify that I am a registered intern in the State of Connecticut.

Registration Number: PCI. _____ Expiration Date: _____ / _____ / _____

I certify under penalty of law that the information provided in this statement is true to the best of my knowledge.

Name of Intern: _____
(First, Last)

Signature of Intern: _____ Date: ____ / ____ / _____

Part II: To be completed by the Pharmacist Preceptor

I hereby certify that I am a licensed pharmacist in the State of Connecticut.

License Number of Pharmacist Preceptor: PCT. _____

I am the preceptor who supervised the training of _____
(Name of Pharmacy Intern)

for the purpose of gaining intern practical experience, as required by
Section 20-598 of the Connecticut General Statutes and Section 20-576-8 of the
Regulations of Connecticut State Agencies.

**I hereby certify that a total of _____ internship hours were earned
from _____ / _____ / _____ to _____ / _____ / _____ under my
supervision at the following pharmacy:**

Pharmacy Name: _____

Pharmacy Address: _____
(Street)

(City/Town)

(State)

(Zip Code)

License Number of Pharmacy: PCY. _____

I certify under penalty of law that the information provided in this statement is true to the best of my knowledge.

Name of Pharmacist Preceptor: _____
(First, Last)

Signature of Pharmacist Preceptor: _____

Date Signed: _____ / _____ / _____